(3)

No. 87-818

Supreme Court, U.S.
FILED
JAN 22 1988
JOSEPH F. SPANIOL, JR.
CLERK

In the Supreme Court
OF THE
United States

OCTOBER TERM, 1987

KIP HAYES,
Petitioner,

VS.

PRUDENTIAL INSURANCE COMPANY OF AMERICA,
NATIONAL LEAGUE OF POSTMASTERS
OF THE UNITED STATES, et al.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION BY RESPONDENT THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

JAMES S. CLINE*
ANGEL GOMEZ, III
ADAMS, DUQUE & HAZELTINE
523 West Sixth Street
Los Angeles, California 90014
(213) 620-1240

Attorneys for Respondent
The Prudential Insurance
Company of America

* Counsel of record

Bowne of Los Angeles, Inc., Law Printers. (213) 742-6600

7 1 PP

QUESTIONS PRESENTED

This case does not involve insurance in the traditional sense. This case involves a "Health Benefits Plan" for federal employees, created by the Federal Employees Health Benefits Act of 1959 ("FEHBA"). 5 U.S.C. §§ 8901-8913. Respondent National League of Postmasters of the United States ("Postmasters") is an association of federal employees and is a "carrier" under FEHBA. Postmasters, as a carrier, provides health care benefits to federal employees through a Health Benefits Plan ("Plan").

Respondent The Prudential Insurance Company of America ("Prudential") administered claims presented to Postmasters for payment and, in effect, guaranteed Postmasters' solvency to pay valid claims. Prudential did not insure the federal employees who enrolled in the Postmasters' Health Benefits Plan.

The questions presented are:

1. Where FEHBA Health Benefits Plans come into existence through a federal contract, are subject to direct oversight by a federal agency, are funded by the federal treasury for the benefit of federal employees pursuant to a federal statute, and, where FEHBA itself contains an express preemption clause, whether disputes concerning FEHBA Health Benefits Plan benefits and administration shall be governed exclusively by federal law and all state law claims be preempted?

2. Whether Prudential is a proper party defendant in this matter and whether any claim is cognizable at all against Prudential under either federal or state law?

LIST OF PARTIES

The parties to the proceedings below were petitioner Kip Hayes, respondent National League of Postmasters of the United States, the Office of Personnel Management, an agency of the United States ("OPM"), Nobel Hayes, and respondent The Prudential Insurance Company of America.*

---

*A list of Prudential's subsidiaries and affiliates pursuant to Rule 28.1 is contained in Appendix "G," attached hereto.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
LIST OF PARTIES	ii
OPINIONS BELOW	1
JURISDICTION	2
STATUTE AND REGULATIONS INVOLVED	3
STATEMENT OF THE CASE	3
REASONS TO DENY THE PETITION	3
I.	
SUMMARY OF ARGUMENT	3
II.	
THE NINTH CIRCUIT CORRECTLY DECIDED THAT CALIFORNIA INSURANCE LAW IS PREEMPTED BY FEDERAL LAW AND CANNOT THEREFORE APPLY	5
A. Under Applicable Preemption Doctrine, State Insurer Torts Would Defeat the Full Purpose and Objective of Congress	5
B. State Claims Processing Torts Directly Conflict With Federal Contractual, Statutory and Regulatory Remedies	8
C. FEHBA Plans Are Federal Procurement Contracts, Not Insurance	11
D. Petitioner's Remaining Arguments Regarding Preemption Are Inapposite or Unpersuasive	12
III.	
PETITIONER COMES BEFORE THIS COURT REQUESTING AN ADVISORY OPINION.	13

TABLE OF CONTENTS

Page

IV.

PRUDENTIAL AS AN "UNDERWRITER" AND AGENT IS NOT A PROPER PARTY AMENABLE TO SUIT UNDER FEDERAL OR STATE LAW 14

V.

THE DECISION IN *HOWARD V. GROUP HOSPITAL SERVICE* IS NOT IN CONFLICT AND IS INAPPOSITE 17

CONCLUSION 18

APPENDICES

Appendix A

Order Granting Defendant's Motion for Summary Judgment, United States District Court, Southern District of California

Appendix B

Opinion, United States Court of Appeals for the Ninth Circuit

Appendix C

Order, United States Court of Appeals for the Ninth Circuit

Appendix D

Code of Federal Regulations 29 C.F.R.

Appendix E

Order Granting Plaintiff's Motion for Summary Judgment, United States District Court, Central District of California

TABLE OF CONTENTS

Appendix F

Memorandum, United States District Court for the Middle District of Pennsylvania

Order, United States District Court for the Middle District of Pennsylvania

Appendix G

List of companies supplied pursuant to Rule 28.1

TABLE OF AUTHORITIES

Cases

Page

Allis-Chalmers Corp. v. Lueck, 471 U.S. 202, 105 S.Ct. 1904, 85 L.Ed.2d 206 (1985) 8, 9, 13, 18

Atlas Pallet, Inc. v. Gallagher, 725 F.2d 131, (1st Cir. 1984) 6

Austero v. Nat. Cas. Co., 62 Cal. App. 3d 511, (1976) 15, 16

Blue Cross & Blue Shield v. Dept. of Banking, 791 F.2d 1501 (11th Cir. 1986) 13

Clearfield Trust Co. v. United States, 318 U.S. 363, 65 S.Ct. 573, 87 L.Ed. 838 (1941) 12

Delancy v. Nat. Post Office Mail Handlers, No. 84-0695 (M.D. Pa. 1985) 9, 12

Director, Edward Meyer Hospital v. Stetz, 433 F. Supp. 323 (W.D.N.Y. 1977) 15

Egan v. Mutual of Omaha Ins. Co., 24 Cal.3d 809 (1979), *cert. denied and appeal dismissed,* 455 U.S. 912 (1980) 15

Fields v. Blue Shield of California, 163 Cal. App. 3d 570 (1985) 12

Gruenberg v. Aetna Ins. Co., 9 Cal.3d 566 (1973) 15, 16

Hartenstine v. Superior Court, 196 Cal. App. 3d 206 (1987) 4, 9, 10, 12, 13, 17, 18

Hayes v. Prudential, 819 F.2d 921 (9th Cir. 1987) 10, 13

Howard v. Group Hospital Service, 739 F.2d 1508 (10th Cir. 1984) 17, 18

Iverson v. Superior Court, 57 Cal. App. 3d 168 (1976) 16

TABLE OF AUTHORITIES

CASES

Page

Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985) *rev'g on other grounds*, 722 F.2d 482 (9th Cir. 1983) 8, 18

Metropolitan Life Ins. Co. v. Curtis, No. CV-83-167 MML (C.D. Cal. 1983) 6

Metropolitan Life Ins. Co. v. McSheen, 577 F. Supp. 165 (N.D. Cal. 1983) 6

Pilot Life v. Dedeaux, ____ U.S. ____, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987) 8, 11, 13, 18

Ridgway v. Ridgway, 454 U.S. 46, 102 S.Ct. 49, 75 L.Ed.2d 39 (1981) 6

Shaw v. Delta Airlines, 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983) 8

Suydam v. United States, 404 F.2d 1329 (D.C. Cir. 1968) 6

United States v. Allegheny County, 322 U.S. 174, 64 S.Ct. 908, 88 L.Ed. 209 (1944) 12

Federal Regulations

Code of Federal Regulations, Title 5, Part 890 .....3, 10, 14

Miscellaneous

House of Representatives Report No. 282, 95th Cong., 1st Sess. 5 (May 10, 1977) 7

Senate Report No. 95-903, 95th Cong., 2d Sess., *reprinted in* 1978 U.S. Code Cong. & Ad. News 1413 .....7, 11, 12

TABLE OF AUTHORITIES

MISCELLANEOUS

	Page
Testimony of Thomas Tinsley, Dir., Bureau of Retirement, Insurance, and Occupational Health, U.S. Civil Service Commission before Senate Subcommittee on Civil Service and General Services (September 14, 1977)	7

Statutes

Employee Retirement Income Security Act (29 U.S.C. § 1144)	8
Federal Employees Health Benefits Act of 1959 (5 U.S.C. § 8901)	i, 3
Labor Management Relations Act of 1947 (29 U.S.C. § 185(a))	9
McCarran-Ferguson Act (15 U.S.C. § 1011)	12
United States Code, Title 5, sec. 8701	6
United States Code, Title 5, sec. 8709	6
United States Code, Title 5, sec. 8902	16
United States Code, Title 5, sec. 8902(e)	10
United States Code, Title 5, sec. 8902(m)(1) ...	5, 6, 8
United States Code, Title 28, sec. 1254(1)	2
United States Code, Title 28, sec. 1331	2
United States Code, Title 28, sec. 1441(b)	17
United States Code, Title 29, sec. 8902(m)(1)..	8
United States Code, Title 38, sec. 801	6
United States Code, Title 38, sec. 765	6

CASE NO. 87-818

In the Supreme Court

OF THE

United States

OCTOBER TERM, 1987

KIP HAYES,
Petitioner,

VS.

PRUDENTIAL INSURANCE COMPANY OF AMERICA,
NATIONAL LEAGUE OF POSTMASTERS
OF THE UNITED STATES, et al.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION BY RESPONDENT THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

OPINIONS BELOW

The Order of the United States District Court, Southern District of California (Nielson, L.C.), granting respondents' motion for summary judgment has not been reported. It is re-printed in Appendix "A", attached hereto.

The opinion of the United States Court of Appeals for the Ninth Circuit affirming the district court's order granting respondents' motion for summary judgment is

reported at 819 F.2d 921 (9th Cir. 1987), and is reprinted in Appendix "B", attached hereto.

The order of the United States Court of Appeals for the Ninth Circuit denying petitioner's petition for rehearing in the Ninth Circuit Court of Appeals, is reprinted in Appendix "C", attached hereto.

JURISDICTION

Petitioner originally brought this action in the Superior Court of California, County of San Diego, on April 16, 1984. Respondent Postmasters removed the action to the United States District Court for the Southern District of California, alleging federal jurisdiction pursuant to 28 U.S.C. §§ 1331, 1332(a) and 1441.

Respondents brought a motion for summary judgment. This motion was granted by the District Court on January 14, 1985.

Petitioner filed a timely appeal to the Ninth Circuit Court of Appeals. On June 15, 1987, the Ninth Circuit Court of Appeals issued an order affirming the District Court's order. The petition for rehearing was timely sought and subsequently denied on July 21, 1987.

On October 2, 1987, Justice O'Connor ordered that the time for filing the petition for a writ of certiorari be extended through November 18, 1987. The jurisdiction of this Court to review the judgment of the Ninth Circuit is sought pursuant to 28 U.S.C. § 1254(1). The Petition was timely filed.

On December 4, 1987, permission was granted by this Court to respondents that the Briefs in Opposition to the Petition may be filed on or before January 22, 1988.

STATUTE AND REGULATIONS INVOLVED

The Federal Employees Health Benefits Act of 1959, 5 U.S.C. §§ 8901-8913. Pertinent sections of FEHBA are reprinted in petitioner's Appendix at D-1 through D-56.

Title 5 C.F.R. Part 890. These regulations, in pertinent part, are reprinted in Appendix "D", attached hereto.

STATEMENT OF THE CASE

Prudential hereby adopts and incorporates by reference as though set forth in full herein the Statement of the Case in the Opinion below by the United States Court of Appeals for the Ninth Circuit, 819 F.2d 921 (9th Cir. 1987) (Appendix "B"). Further, Prudential hereby adopts and incorporates by reference as though set forth in full the Statement of the Case set forth in the Brief in Opposition, and appendices thereto, filed in this matter by respondent Postmasters.

REASONS TO DENY THE PETITION

I.

SUMMARY OF ARGUMENT

Petitioner seeks to take an unusual set of facts, and insert a unique reading of a state law into federal contracts affecting federal employees. Moreover, this result is sought in a procedural context that renders this Court's opinion strictly advisory.

Petitioner wishes to use the California state law covenant of good faith and fair dealing to regulate the relationship between OPM and Postmasters, and to alter the federal contracts between all the parties here. This Petition does not meet the standards of this Court for the granting of a Petition for Writ of Certiorari.

First, based on express statutory and regulatory provisions, legislative history, and relevant case law, the decision below by the Ninth Circuit is correctly decided. Second, there is no bona fide conflict among the Courts of Appeals for the Circuits. The only Court of Appeals case cited by petitioner as "in conflict" is not apposite, and is not in conflict. Third, petitioner has adopted a highly strained and incorrect view of California state law. Even if California state law were applied, petitioner could not prevail.

Although petitioner attempts to garb himself under the broad theoretical cloak of "preemption," in fact, his main argument is very limited and almost outlandish. Petitioner proposes that under the facts of this case, California state law be inserted into the relationship between OPM, a federal agency, and Postmasters, a federal contractor, to contradict rights expressly given by federal statute to Postmasters. (*Petition*, p. 14 n.13). This type of intrusion by state law into the federal province was expressly prohibited by Congress with the passage of FEHBA.

A recent California Court of Appeal case has recognized these dangers and has held that FEHBA preempts all California state law claims for relief. *Hartenstine v. Superior Court*, 196 Cal. App. 3d 206 (1987).

Finally, no effective appeal was taken from a decision below and the action sought from this Court is only an advisory opinion.

II.

THE NINTH CIRCUIT CORRECTLY DECIDED THAT CALIFORNIA INSURANCE LAW IS PREEMPTED BY FEDERAL LAW AND THEREFORE CANNOT APPLY.

Petitioner presents to this Court the proposition that a federal employee Health Benefits Plan created by federal statute for federal employees and paid for in major part by the federal treasury should be subject to overriding state regulation.

Express congressional intent and an obvious federal interest in uniformity of benefits and procedures outweigh the interests of individual states which seek to impose differing standards on these federal employee Health Benefits Plans.

A. Under Applicable Preemption Doctrine, State Insurer Torts Would Defeat the Full Purpose and Objective of Congress.

State tort actions are expressly preempted by FEHBA. Congressional intent to preempt state law is apparent from 5 U.S.C. § 8902(m)(1), which provides:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits *(including payments with respect to benefits) shall supersede and preempt any state or local law,* or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions. (Emphasis added.)

The Ninth Circuit correctly relied upon this clear language in its decision below that California state laws

purporting to add additional procedures and remedies are preempted.[1]

The Ninth Circuit also cited a portion of the legislative history to support its conclusion. Indeed, a more detailed view of the legislative history of § 8902(m)(1) establishes firmly that Congress intended to supersede the application of all state claims-processing laws.

Alan Campbell, Chairman of the Civil Service Commission, then responsible for oversight of federal Health Benefits Plans, proposed and urged the passage of § 8902(m)(1). A letter from Mr. Campbell to Senator Abraham A. Ribicoff, Chairman of the Committee on Governmental Affairs articulated the problem of inconsistency within the fifty states in regard to FEHBA:

> In terms of contracting with the carrier, it was reaching a point where unless we were to negotiate contracts that included all the requirements of the various State laws and applied them nationwide, we

---

[1]This Court, and other courts, have recognized that parallel preemption provisions under similar federal statutes have conclusive preemptive effect. An example is *Metropolitan Life Ins. Co. v. McSheen*, 577 F. Supp. 165 (N.D. Cal. 1983) which held that federal law will be used to interpret the terms of a group life insurance policy offered as a fringe benefit to federal employees pursuant to the Federal Employees Group Life Insurance Act, 5 U.S.C. § 8701 *et seq.* *See also, e.g.*, Servicemens Group Life Insurance Act, 38 U.S.C. § 765 *et seq.*, given preemptive effect in *Ridgway v. Ridgway*, 454 U.S. 46, 102 S.Ct. 49, 75 L.Ed.2d 39 (1981); Federal Employee's Group Life Ins. Act, 5 U.S.C. § 8709, given preemptive effect in *Metropolitan Life Ins. Co. v. Curtis*, No. CV-83-167 MML (C.D. Cal. 1983) (reprinted in Appendix "E", attached hereto). *Accord Atlas Pallet, Inc. v. Gallagher*, 725 F.2d 131, 135 (1st Cir. 1984) (federal law governs policies issued pursuant to National Flood Insurance Program); *Suydam v. United States*, 404 F.2d 1329, 1331 (D.C. Cir. 1968) (federal law governs policies issued by National Service Life Insurance, 38 U.S.C. § 801 *et seq.*

> would continue to place our carriers in a position where they would not be in compliance with some State law. In addition, many of the State laws were in conflict with each other.

S. Rep. No. 95-903, 95th Cong., 2d Sess. ("S. Rep. No. 95-903") *reprinted in* 1978 U.S. Code Cong. & Ad. News 1413, 1419.

As FEHBA moved through the passage process, additional legislative history set out a broad interpretation of the preemption provision in Section 8902(m)(1). Senate Report No. 95-903 concludes that only state laws dealing with technical matters such as "the payment of premium taxes and requirements for statutory reserves" are to survive the effects of Section 8902(m)(1). (S. Rep. 95-903, *reprinted in* 1978 U.S. Code Cong. & Ad. News 1413, 1415.)[2] Petitioner's state law causes of action relating to claims administration do not fall within this category.

A fair reading of the entire legislative history indicates that Congress and the Civil Service Commission (predecessor to OPM) were extremely concerned about displacing all state regulation of federal employee Health Benefits Plans. Congress intended that federal employee Health Benefits Plans have national uniformity of benefits and procedures.[3]

---

[2]The parallel House Report containing FEHBA legislative history, H. R. Rep. No. 282, 95th Cong., 1st. Sess. 5 (May 10, 1977) also makes clear that the only state regulations to be permitted were taxes and technical rules such as those involving maintenance of reserves. The content of plan coverage and matters "relating to health benefits" were expressly preempted.

[3]*See, e.g.*, Testimony of Thomas Tinsley, Dir., Bureau of Retirement, Insurance, and Occupational Health, U.S. Civil Service Commission before Senate Subcommittee on Civil Service and General Services (September 14, 1977), (Commission needed preemption in areas "where . . . our *administrative* practices are in conflict with

B. State Claims Processing Torts Directly Conflict With Federal Contractual, Statutory and Regulatory Remedies.

Preemption is further indicated by the broad language of § 8902(m)(1) stating that any state law "which relates to health insurance or plans," 29 U.S.C. § 8902(m)(1), will be superceded and preempted. This same wording in § 514 of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144 was construed by this Court in *Shaw v. Delta Airlines,* 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983):[4]

> A law "relates to" an employee benfit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.

463 U.S. at 96-97, 103 S.Ct. at 2900, 77 L.Ed.2d at 501.

Petitioner argues that FEHBA does not preempt state tort causes of action relating to the handling or processing of claims because they do not directly appear to contradict federal law.[5] (*Petition*, p. 21 n.17.) This same

---

State laws") p. 3; ("... in terms of *administrative* matters ... State laws would not be controlling in these areas.") p. 6; (preemption "would preserve the principle of uniformity of benefits and *administration* for enrollees in each FEHB Plan.") p. 5. (Emphasis added).

[4] *Accord Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985) *rev'g on other grounds*, 722 F.2d 482 (9th Cir. 1983) (*see* fn.4), and *Pilot Life v. Dedeaux*, ____ U.S. ____, 107 S. Ct. 1549, 95 L.Ed.2d 39 (1987).

[5] Petitioner's argument that § 8902(m)(1) "does not conflict" with the state tort actions misses another obvious point. Petitioner's argument avoids any conflict simply by having state law interpret the underlying contract — the state tort would not conflict with the contract because state law would interpret the contract.

This circular argument cannot stand. The issue is which law provides the contract interpretation. Congress has made clear that only federal law will provide the necessary national uniformity.

point was rejected by this Court in *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 105 S.Ct. 1904, 85 L.Ed.2d 206 (1985) and by the California Court of Appeal in *Hartenstine v. Superior Court*, 196 Cal. App. 3d, 206, 217 (1987).[6]

In *Lueck*, a union-represented employee sought to bring state insurer tort actions against the insurance company engaged by his employer to provide disability insurance under a private employee benefits plan. The question arose whether § 301 of the Labor Management Relations Act of 1947, 29 U.S.C. § 185(a), preempted state tort law. This Court found preemption, rejecting an argument identical to the one raised by petitioner here.

In *Lueck*, the plaintiff asserted that state tort claims were "independent" of any contract claim, for example, the state tort of "unreasonably delaying payment". This Court said:

> [I]t is a question of federal contract interpretation whether there was an obligation under this labor contract to provide payments in a timely manner, and, if so, whether [the employer's] conduct breached that implied contract provision.

471 U.S. at 215, 105 S.Ct. at 1913, 85 L.Ed.2d at 218.[7]

---

[6]*Accord Delancy v. Nat. Post Office Mail Handlers*, No 84-0495 (M.D. Pa. June 25, 1985), reprinted in Appendix "F," attached hereto.

[7]This Court continued in *Lueck:*

> The duties imposed and rights established through the state tort thus derive fom the rights and obligations established by the contract. . . . That being so, this tort claim is firmly rooted in the expectations of the parties that must be evaluated by federal contract law. * * *
>
> Because the right asserted not only derives from the contract, but is defined by the contractual obligation of good faith, any

The identical reasoning has been adopted by the California Court of Appeal in a dispute concerning a FEHBA Health Benefits Plan. In *Hartenstine, supra* at 218, the California Court of Appeal, citing favorably and quoting the Ninth Circuit's opinion below, held:

> "Tort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract."

Id. (quoting Hayes v. Prudential, 819 F.2d 921, 936 (9th Cir. 1987)).

Petitioner's further argument that there is no federal comprehensive civil enforcement mechanism under FEHBA (*Petition,* p. 27) is incorrect. FEHBA, and regulations issued pursuant to it, have a complete claims review procedure, 5 C.F.R. § 890.105, a hearing procedure, 5 C.F.R. § 890.106, and bases for legal causes of action against a carrier or OPM, 5 C.F.R. § 890.107. In addition, OPM has the authority to prescribe minimum standards of conduct and to withdraw approval from plans. 5 U.S.C. § 8902(e). Approval may be withdrawn from plans which unreasonably fail to pay claims. 5 C.F.R. § 890.205. All of these statutes and regulations are incorporated into the contract negotiated between OPM and Postmasters ("Contract"); state laws which set forth additional remedies are therefore in conflict with the

---

attempt to assess liability here [under a tort theory] inevitably will involve contract interpretation.

* * * These questions of contract interpretation, therefore, underlie any finding of tort liability, regardless of the fact that the state court may choose to define the tort as "independent" of any contract question. Congress has mandated that federal law govern the meaning given contract terms. Since the state tort purports to give life to these terms in a different environment, it is preempted.

471 U.S. at 218-19, 105 S.Ct. at 1914-15, 85 L.Ed.2d at 219-20.

Contract and the incorporated statutes and regulations and are preempted.

Congress did not create a "claims processing tort" in this statutory and regulatory scheme. A state-created claims processing tort plainly conflicts with the fact that Congress did not create a claims processing tort under FEHBA. Congress created the remedies it thought fit and any additional remedies must therefore conflict with that decision.

The presence of this civil enforcement system in FEHBA provides the same reliable indicia of congressional intent as this Court found in ERISA. *Pilot Life v. Dedeaux, supra.* In FEHBA, not only did Congress expressly preempt state laws, it also created the sole remedial scheme. As in ERISA, this combination of actions unmistakably demonstrates congressional intent.[8]

C. FEHBA Plans Are Federal Procurement Contracts, Not Insurance.

FEHBA is a program heavily subsidized by the government for federal employees. The federal government, and hence the taxpayers, provides more than 60% of the necessary funding for the program.[9] There is a strong

---

[8]Petitioner's argument that a "comprehensive civil enforcement scheme", as found in *Pilot Life v. Dedeaux,* ____ U.S. ____, 107 S. Ct. 1549, 95 L.Ed.2d 39 (1987), is a *sine qua non* for preemption is incorrect. (*Petition,* pp. 21-27). This Court's discussion on that point in *Pilot Life* was occasioned by the "savings clause" contained in ERISA, 29 U.S.C. § 1144(c), and came only after there had been a finding of preemption even without such a "comprehensive civil enforcement scheme." The absence of such a "scheme" does not defeat preemption, and its presence, as in FEHBA, strongly reinforces preemption.

[9]For example, in 1976 the federal government paid $1.4 billion of the total program cost of $2.2 billion. S. Rep. No. 95-903, *reprinted in* 1978 U.S. Code Cong. & Ad. News 1413, 1414.

federal interest, therefore, to assure that federal law control the administration of the program so the government may control the scope and costs of the program necessary to maintain its existence.[10] Imposition of liability for bad faith and punitive damages will severely restrict the federal purposes underlying the act.

The court in *Delancy v. Nat. Post Office Mail Handlers,* No. 84-0695 (M.D. Pa. 1985) (Appendix "F") specifically found that FEHBA Health Benefits Plans are not insurance, and are a "government procurement contract."[11]

D. Petitioner's Remaining Arguments Regarding Preemption Are Inapposite or Unpersuasive.

Petitioner's argument concerning the case of *Fields v. Blue Shield of California,* 163 Cal. App. 3d 570 (1985), must be viewed in light of the very recent *Hartenstine* case, *supra.*

In *Hartenstine,* the child of a federal employee, a FEHBA Health Benefits Plan enrollee, was admitted to a hospital for psychiatric treatment. The carrier in that

---

[10]This impact on the federal treasury alone should result in a very strong federal interest. *See, e.g., Clearfield Trust Co. v. United States,* 318 U.S. 363, 367, 65 S.Ct. 573, 87 L.Ed. 838 (1941).

Moreover, it is a commonplace that only federal law will control contract interpretation of federal procurement contracts. *United States v. Allegheny County,* 322 U.S. 174, 183, 64 S. Ct. 908, 88 L.Ed. 209 (1944).

[11]While technically not insurance, FEHBA does "relate to the business of insurance" as that phrase is used in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, and is therefore not in conflict with that Act. 15 U.S.C. § 1012(b). Moreover, the FEHBA legislative history specifically states that McCarran-Ferguson would not affect FEHBA's goal of federal preemption. (*See* S. Rep. No. 95-903 at 8 (1978), Statement of Alan Campbell, Chairman of the Civil Service Commission).

case declined to pay for certain hospital days because the days had not been "medically necessary" as that term was defined under the Plan. The federal employee brought suit alleging state law-based causes of action, including breach of contract and breach of a covenant of good faith and fair dealing.

The California Court of Appeal held that all state law causes of action were preempted by FEHBA. The Court of Appeal, citing federal law,[12] held that state claims processing torts invariably conflict with federal obligations and are therefore preempted. *Hartenstine, supra* at 221.

III.

PETITIONER COMES BEFORE THIS COURT REQUESTING AN ADVISORY OPINION.

No effective Notice of Appeal was in fact filed from the district court's binding decision below. The district court issued two summary judgment orders in two related, but not consolidated, matters before it. An effective Notice of Appeal was taken only from one of those two orders.

Nobel Hayes, a federal enrollee in the Postmasters' Plan and the father of Kip Hayes, petitioner here, was a defendant in the declaratory judgment action, Civil Action No. 84-0341(M). In the declaratory judgment action, the district court ruled that benefits were properly reduced to $10,000 per year. Nobel Hayes did not file a Notice of Appeal from this Order against him. The son, as a dependent beneficiary, cannot have greater rights than those of his father — the district court's order is as

---

[12] *Pilot Life v. Dedeaux, supra; Allis-Chalmers v. Lueck, supra; Blue Cross & Blue Shield v. Dept. of Banking,* 791 F.2d 1501 (11th Cir. 1986); *Hayes v. Prudential Ins. Co., supra.*

binding on the son, as it is on the father. At the same time, however, Kip Hayes could not take an appeal from the declaratory relief action to which he was not a party.

The declaratory relief action order conclusively showed that no contract right was breached by respondents, and that state law causes of action were preempted. These conclusions are binding on Kip Hayes through the unappealed order binding on his father. Kip Hayes cannot now collaterally challenge these conclusions. Therefore, the instant Petition must be viewed as an advisory opinion. This is, of course, not an appropriate basis upon which to grant a petition for writ of certiorari.

Petitioner compounds this problem by not challenging in his Petition that portion of the opinion of the Ninth Circuit below holding that there has been no contract breach. Petitioner does not challenge in this Petition that the benefit level was properly reduced under applicable contract language and federal law.

This failure to appeal to the Ninth Circuit and failure to challenge herein the declaratory relief action order renders this Petition strictly advisory.

IV.

PRUDENTIAL AS AN "UNDERWRITER" AND AGENT IS NOT A PROPER PARTY AMENABLE TO SUIT UNDER FEDERAL OR STATE LAW.

Section 890.107 of the Code of Federal Regulations provides in pertinent part:

> An action to recover on a claim for health benefits should be brought against the *carrier* of the health benefits plan. An action to review the legality of OPM's regulation or a decision made by OPM should

> be brought against the Office of Personnel Management, Washington, D.C., 20415.

(Emphasis supplied.)

Article 2, Section 2.1 of the Contract between OPM and Postmasters establishes that Postmasters is the "carrier" and Prudential is the "underwriter." Since the regulation allows suits for benefits only against the "carrier" of the plan, Prudential, as the "underwriter," is not amenable to suit.[13]

Moreover, even if state law were to apply, petitioner may not maintain any claim for relief against Prudential.

The Contract between OPM and Postmasters is the source of Petitioner's claims for health benefits. Prudential, however, is not a party to that Contract: Prudential is an agent. As an agent, and not a party to the underlying contract, Prudential cannot be liable under California state law for a breach of a state law covenant of good faith and fair dealing in a contract it does not sign. *Egan v. Mutual of Omaha Ins. Co.*, 24 Cal.3d 809, 824 (1979), *cert. denied and appeal dismissed*, 455 U.S. 912 (1980); *Gruenberg v. Aetna Ins. Co.*, 9 Cal.3d 566, 576 (1973); *Austero v. Nat. Cas. Co.*, 62 Cal. App. 3d 511, 515 (1976);

---

[13]In *Director, Edward Meyer Hospital v. Stetz*, 433 F. Supp. 323 (W.D.N.Y. 1977), a claim for hospital services filed by Stetz, a federal employee, had been denied. Stetz brought an action against the carrier, the United States Civil Service Commission ("Commission") (now OPM) and the United States to obtain reimbursement for the cost of Stetz' hospitalization. The court dismissed claims against the Commission and the United States, holding:

> Under the regulations promulgated by the Commission [now OPM], actions such as this suit are specifically authorized only against the carrier.

Id. at 325.

Iverson v. Superior Court, 57 Cal. App. 3d 168, 171 (1976).[14]

In addition, petitioner's suggested use of a state law covenant of good faith and fair dealing to regulate the relationship between OPM and Postmasters is almost surrealistic. (*Petition*, p. 14 n.13) Under FEHBA, OPM and Postmasters negotiate on an annual basis the terms of the following year's Plan. The statute is clear that the independent concurrence of both parties is necessary to reach agreement or amend a contract. OPM has no authority unilaterally to direct that Postmasters agree to any particular benefit. 5 U.S.C. § 8902.

Petitioner's argument that a state law can override this express federal statute between a federal agency and federal contractor has no support in case law or logic. In effect, petitioner argues that state law should preeempt federal law.

Moreover, even if viewed strictly as a matter of state law, petitioner's argument is meaningless because a federal employee Health Benefits Plan is *not* insurance; hence, California doctrines concerning insurance policies

---

[14]In *Austero*, the California Court of Appeal held that the duty of good faith and fair dealing "derives from and exists solely because of" the contractual relationship between the parties, and that one who is not a "party to the underlying contract" may not be held liable for breach of an implied covenant, because "as to him no such convenant exists." *Id.* at 515. *Iverson* also holds that one who is not party to the insurance contract "is not bound by the implied covenant [of good faith and fair dealing] and owes no duty to the insured not to breach it." *Id.* at 171. In *Gruenberg*, the California Supreme Court ruled that agents and employees are "not parties to the agreements for insurance," and therefore "are not subject to an implied duty of good faith and fair dealing." It held that an action may not lie against an agent for breach of an implied covenant of good faith and fair dealing. *Id.* at 576. *Egan* expressly reaffirms *Gruenberg*, holding that agents are "not subject to the implied covenant." *Id.* at 824.

are inapplicable. Second, in any event, no California case has ever suggested that a good faith covenant requires a contract between an insurance company and a third party must be amended to provide an extension of non-vested coverage to an insured.

Finally, among other problems, there can be no breach of a covenant of good faith and fair dealing without a breach of the underlying contract. Petitioner acknowledges that there has been no breach of contract by his failure to challenge that portion of the Ninth Circuit's opinion below.

In summary, even if state law were to apply, petitioner could not prevail on any state-law based claim for relief.

V.

THE DECISION IN *HOWARD V. GROUP HOSPITAL SERVICE* IS NOT IN CONFLICT AND IS INAPPOSITE.

The California Court of Appeal in *Hartenstine, supra*, accurately analyzed *Howard v. Group Hospital Service*, 739 F.2d 1508 (10th Cir. 1984), when it stated:

> [In *Howard*,] the Court held that a suit in an Oklahoma state court for damages in contract and tort resulting from Blue Cross' failure to pay claims under an FEHBA plan should not have been removed to the United States District Court on the basis of federal question jurisdiction (28 U.S.C. § 1441(b)). However, the analysis in *Howard* was limited to the contract claim; there was no reference to preemption in the majority opinion, and, as the concurring opinion stated, the existence of a federal preemption defense would be insufficient to invoke the exercise of removal jurisdiction. Accordingly, the

holding on *Howard* is irrelevant to the preemption issue in the case here.

* * *

Further, if we were to apply the reasoning in *Howard* on the jurisdiction issue to Hartenstine's tort claims in the case here, the result would be contrary to section 8902(m)(1)'s purpose, *supra*, of promoting uniformity in the administration of FEHBA's benefits.

Hartenstine, supra at 218-19.

The Tenth Circuit in *Howard* did not need to reach the issues upon which the Petition in this case relies. The discussion in *Howard* cited by petitioner is strictly *dictum*. Purported conflict with *dictum* in another Court of Appeals decision is not a sufficient ground upon which to grant a Petition for Writ of Certiorari.[15]

CONCLUSION

For the reasons set forth above, the Petition for Writ of Certiorari should be denied.

January 22, 1988.

Respectfully submitted,

JAMES S. CLINE
ANGEL GOMEZ, III
ADAMS, DUQUE & HAZELTINE

---

[15]In any event, this Court's analysis in *Massachusetts Mutual Life Ins. Co.* v. *Russell, supra, Allis-Chalmers v. Lueck, supra,* and *Pilot Life v. Dedeaux, supra,* discussed in Section II, *supra,* leaves the reasoning in *Howard* in serious question.

APPENDIX A

APPENDIX A

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

KIP HAYES,
Plaintiff,
v.
PRUDENTIAL INSURANCE COMPANY,
NATIONAL LEAGUE OF POSTMASTERS
OF THE UNITED STATES,
and NOBEL A. HAYES,
Defendants.

Civil No. 84-1245-N(M)

ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

FILED, JAN. 22, 1985
ENTERED, JAN. 23, 1985
Clerk, U.S. District Court Southern District of California
By S. Miller, Deputy

This matter came before this Court on January 14, 1985, for hearing on the motion for summary judgment of defendants Prudential Insurance Company and National League of Postmasters. Plaintiff Kip Hayes appeared by Harvey R. Levine of Shernoff & Levine. Defendant Prudential Insurance Company appeared by James S. Cline of Adams, Duque & Hazeltine, and defendant National League of Postmasters appeared by John T. Kotelly of Dickstein, Shapiro & Morin. Upon consideration of the arguments of counsel and the moving and opposing papers:

IT IS HEREBY ORDERED that defendants' motion for summary judgment is granted as to all counts of the plaintiff's complaint. This Court concludes as to counts

one and two of the complaint that benefits for private duty nursing care have been lawfully reduced to $10,000 per person per year in the 1984 Postmasters Benefit Plan and that defendants are not obligated to pay claims for private duty nursing benefits in excess of this amount during 1984 nor during any year thereafter so long as the limitation remains. As to the remaining counts in plaintiff's complaint, this Court concludes that these claims under California state laws are preempted under Title V, United States Code section 8902(m)(1).

IT IS SO ORDERED.

Dated: January 22, 1985.

LELAND C. NIELSEN,
United States District Judge

Copies to:

John T. Kotelly
DICKSTEIN, SHAPIRO & MORIN
2101 L Street, N.W.
Washington, D.C. 20037

Marcia Hughes
CASEY, GERRY, CASEY,
WESTBROOK, REED & HUGHES
110 Laurel Street
San Diego, CA 92101

Harvey R. Levine
Rick L. Bove
SHERNOFF & LEVINE
1200 Third Avenue, Ste. 1400
San Diego, CA 92101-4157

John J. Robinson,
Assistant U. S. Attorney

Raymond J. Coughlan, Jr.
LILLICK, MCHOSE & CHARLES
110 West A St., Ste. 1260
San Diego, CA 92101

James S. Cline
ADAMS, DUQUE & HAZELTINE
523 W. Sixth Street
Los Angeles, CA 90014

APPENDIX B

FOR PUBLICATION

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

KIP HAYES,

Plaintiff-Appellant,

v.

PRUDENTIAL INSURANCE COMPANY OF AMERICA, NATIONAL LEAGUE OF POSTMASTERS OF THE UNITED STATES, et al.,

Defendants-Appellees.

Nos. 85-5527; 85-5528

D.C. Nos. CV-84-1245-LCN CV-84-0341-LCN

OPINION

Argued and Submitted
November 4, 1985—San Diego, California

Filed June 15, 1987

Before: James R. Browning, Charles Wiggins and Melvin Brunetti, Circuit Judges.

Opinion by Judge Brunetti

Appeal from the United States District Court for the Southern District of California
Leland C. Nielsen, District Judge, Presiding

SUMMARY

Public Employees

Appeal from two summary judgments. Affirmed.

Appellant Kip Hayes (Kip) is the son of Nobel Hayes (Hayes), a retired federal employee. Kip was injured in a high

school football game and became a respirator-dependent quadriplegic requiring 24-hour private duty nursing care. At the time of the injury Kip was covered as a family member on his father's plan issued under the FEHBA. The plan, administered by Aetna Life Insurance Company, placed no monetary limit on the benefits for private duty nursing care. When the Aetna plan was modified to eliminate such benefits, Hayes enrolled in another FEHBA plan during an open season enrollment period during which changes were permitted. In 1982 Hayes switched to a plan offered by the National League of Postmasters (NLP). In 1983 the NLP was formulated to place a $10,000 limit on benefits for private duty nursing care. The limit was lifted for 1983, but instituted for 1984 and future years.

In February 1984, NLP filed a declaratory relief action in district court naming the Office of Personnel Management (OPM) [which negotiated with NLP regarding the scope of coverage of the plan] and Hayes as defendants. The district court granted summary judgment in favor of NLP on the ground that benefits for private duty nursing care lawfully had been reduced to $10,000 in the 1984 plan. In April 1984 Kip brought an action against NLP in state court arguing that his enrollment in the 1982 plan gave him a vested contractual right to receive, indefinitely, unlimited private duty nursing care benefits. The action was removed to federal district court where the court granted summary judgment in favor of the defendants on the grounds that the benefits lawfully had been reduced, and that the state law claims were preempted under FEHBA.

[1] Although neither Hayes or the OPM appealed the declaratory judgment action in favor of NLP, Kip requested that he be joined as a defendant in that action and the court consolidated the two cases. Kip therefore effectively appealed from the summary judgment in the declaratory relief suit.

[2] An FEHBA provision requiring that a carrier agree to pay in an individual case if OPM finds the family member is

entitled to payment under the terms of the contract does not grant OPM authority unilaterally to alter the terms of the plan, but only requires that the carrier comply with the OPM's interpretation of the plan. OPM's consistently held view is that appellant is not entitled to unlimited benefits under the plan. [3] Appellant also urges that an FEHBA provision providing for a contingency reserve grants OPM authority to compel a carrier to provide benefits beyond those in the negotiated plan. But the OPM's interpretation of the provision as requiring the carrier's concurrence before contingency reserve funds may be used is entitled to substantial deference. [4] Consistent with this view the OPM never invoked authority to direct payment of the additional benefits, and appellant has not challenged OPM's interpretation of its authority. [5] Appellant also contends that the Catastrophic Protection provision of the plan allows the benefits, [6] but this provision only requires payment of 100% of eligible expenses (as opposed to 80%) in some circumstances and does not operate independent of the $10,000 limitation on private nursing care. [7] The limitation on private duty nursing care restricts the eligible expenses subject to the Catastrophic Protection provision.

[8] Appellant's contention that his state law tort and contract claims are not preempted by FEHBA because the claims relate to the manner in which the claim was processed, not to the nature or extent of coverage or benefits, draws a distinction that cannot be made. Tort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract. [9] Because the state law claims invariably expand obligations under the terms of the plan, the claims are inconsistent with the plan and preempted by FEHBA. This holding is supported by the Supreme Court's decision that the Employee Retirement Income Security Act preempts state common law tort and contract claims for benefits. To the extent the state law claims are predicated on an alleged obligation to provide benefits in excess of the $10,000 limit the claims are moot.

COUNSEL

Harvey R. Levine, Rick L. Bove, and Janet Lewis, San Diego, California, for the plaintiff-appellant.

Edward R. Cohen, John T. Kotelly, Ira Mitzner and Elaine Metlin, Washington, D.C.; James S. Cline, Los Angeles, California; R. J. Coughlin, Jr., San Diego, California, for the defendants-appellees.

Phillip S. Neal, Washington, D.C.; James R. Barnett, Washington, D.C., for the amicus curiae.

OPINION

BRUNETTI, Circuit Judge:

This is an appeal from summary judgments granted in two consolidated cases, *Kip Hayes v. Prudential Insurance Co.*, No. 85-5527 (D.C. No. 84-1245), and *National League of Postmasters of the United States v. United States Office of Personnel Management and Nobel Hayes*, No. 85-5528 (D.C. No. 84-0341). We are asked to review the district court's rulings that federal employee health benefits lawfully may be reduced from year to year, and that the Federal Employee Health Benefits Act preempts state law tort and contract actions.

Though we are moved by the compelling circumstances surrounding Kip Hayes and his family, we find that the statute and health benefits plan we are called upon to construe require an unmistakable result. Until Congress acts to ensure continued coverage for federal enrollees who require long-term care, this court will be powerless to provide appellant with the remedy he seeks.

We affirm the district court.

I. THE FEDERAL EMPLOYEE HEALTH BENEFITS ACT

The Federal Employee Health Benefits Act (FEHBA) established a comprehensive program to provide federal employees and retirees with subsidized health care benefits. 5 U.S.C. §§ 8901-8913 (1982 & Supp. 1987). Under the Act, the United States does not act as an insurer, but, through the Office of Personnel Management (OPM), contracts with various private carriers to develop health care plans with varying coverages and costs. The plans are for a term of one year, and are renegotiated annually.

After OPM negotiates changes with the carriers all federal enrollees are permitted to switch enrollment from one plan to another, regardless of their state of health, during a period called "open season." Each enrollee thus may obtain the most beneficial plan but is not guaranteed the same coverage in future years that had been available the preceding year.

The National League of Postmasters (NLP or Postmasters) is a nonprofit corporation and a carrier under FEHBA. Each year, OPM and Postmasters negotiate a contract that determines the benefits Postmasters will provide that year to enrollees in the Postmasters Health Benefits Plan (Plan). The contract between OPM and Postmasters sets forth the precise terms of coverage under the Plan. OPM then issues a Postmasters Benefit Brochure (Brochure) which provides a complete description of the benefits available to enrollees that year.

For several years, Prudential Insurance Company of America (Prudential) has entered into agreements with Postmasters whereby Prudential issues an annual policy to Postmasters which incorporates the terms and conditions of the Brochure as negotiated by Postmasters and OPM for the year. Pursuant to the policy, Prudential administers certain claims presented to Postmasters for payment and, in effect,

guarantees that Postmasters can pay the benefits due enrollees under the Plan.

II. FACTS AND PROCEEDINGS

Appellant Kip Hayes is the son of Nobel Hayes, a retired federal employee. Appellant was injured in a high school football game in November 1976, and was rendered a respirator-dependent quadriplegic requiring 24-hour private duty nursing care. At the time of his injury, appellant was covered as a family member under a FEHBA plan in which his father was enrolled. This plan, administered by Aetna Life Insurance Company, placed no monetary limit on the benefits for private duty nursing care. When the Aetna plan later was modified to eliminate private duty nursing care benefits, Nobel Hayes enrolled during open season in another FEHBA plan that did provide unlimited benefits for private duty nursing care. By 1982, Nobel Hayes again had switched coverage, and enrolled in the plan offered by Postmasters, which at the time had no limits on benefits for private duty nursing care.

In October 1982, following negotiations between OPM and Postmasters, the 1983 Postmasters Plan was formulated to place a $10,000 limit on benefits for private duty nursing care. By subsequent agreement between OPM and Postmasters, the 1983 Plan was amended to remove the $10,000 limit.

The Postmasters Plans for 1984 and 1985 again contained a $10,000 limit on benefits for private duty nursing care. The 1984 and 1985 Plans were not amended and, through the date of the summary judgments in both cases, contained the $10,000 limitation.

In February 1984, Postmasters filed in district court a declaratory relief action naming OPM and Nobel Hayes as defendants. *NLP v. OPM*, D.C. No. CV-84-0341-LCN. Postmasters sought a declaration that private duty nursing care benefits provided under its 1982 Plan could be reduced in

subsequent policy contract years and that under its 1984 Plan Postmasters was not obligated to provide Kip Hayes with private nursing benefits in excess of $10,000.

In April 1984, appellant brought an action against Prudential and Postmasters in the Superior Court for the State of California. The action was removed to federal district court. *Hayes v. Prudential,* D.C. No. CV-84-1245-LCN. Appellant alleged that his enrollment in the 1982 Plan gave him a vested contractual right to receive, indefinitely, unlimited private duty nursing care benefits, and that Postmasters and Prudential had breached the contract by refusing to provide unlimited benefits in 1984. Based on this theory of his rights under the Plan, appellant sought damages alleging various state law causes of action including breach of a duty of good faith and fair dealing, and breach of Cal. Ins. Code § 790.03 (West 1982).

The district court granted summary judgment in favor of Postmasters in *NLP v. OPM* on the ground that benefits for private duty nursing care lawfully had been reduced to $10,000 in the 1984 Postmasters Plan and that Postmasters accordingly was not required to pay claims in excess of that amount.

In *Hayes v. Prudential,* the court granted summary judgment in favor of defendants on the grounds that the benefits lawfully had been reduced, and that the state law claims were preempted under FEHBA, 5 U.S.C. § 8902(m)(1).

III. DISCUSSION

1. *Effective Appeal.*

Postmasters and OPM contend that there has been no effective appeal from *NLP v. OPM.* The basis for this contention is that neither OPM nor Nobel Hayes, the named defen-

dants, have appealed, and the appeal by Kip Hayes is not effective because he was not a party to the action.

[1] A motions panel of this court, however, has determined that Kip Hayes' appeal in *NLP v. OPM* was effective. In his Memorandum of Points and Authorities in Opposition to Motion for Summary Judgment in the *NLP v. OPM* action, appellant requested that the district court join him as a defendant pursuant to Fed. R. Civ. P. 19. The district court treated appellant's request as a motion for consolidation with *Hayes v. Prudential,* and consolidated the cases. Consolidation by the district court led the motions panel to conclude that Kip Hayes effectively appealed from the summary judgment in *NLP v. OPM.*

2. *Standard of Review.*

We review de novo the district court's decision regarding the $10,000 limit on benefits and the preemption of state law claims. *See Darring v. Kincheloe,* 783 F.2d 874, 876, (9th Cir. 1986) (grant of summary judgment is reviewed de novo). Summary judgment is appropriate when there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c).

3. *$10,000 Limit on Nursing Care Benefits.*

Appellant contends that the district court erred in granting summary judgment for appellees because (1) Postmasters and Prudential were required to comply with an OPM directive to provide him unlimited private duty nursing care benefits, and (2) the Plan's Catastrophic Protection provision requires Postmasters and Prudential to provide nursing care benefits without regard to the $10,000 limitation stated elsewhere in the policy.

a) *OPM Directive.*

Appellant cites two sections of FEHBA which he contends grant OPM the authority to require Postmasters and Prudential to provide him with unlimited nursing care benefits.

[2] 5 U.S.C. § 8902(j) provides that "[e]ach contract under this chapter shall require the carrier to agree to pay for or provide a health service . . . in an individual case if [OPM] finds that the . . . family member . . . is entitled thereto under the terms of the contract." This provision does not grant OPM authority unilaterally to alter or amend the terms of the Plan; it requires only that the carrier comply with OPM's interpretation of the Plan. OPM's consistently held view is that, under the Plan's terms, appellant is *not* entitled to unlimited benefits. As a result, Postmasters and Prudential were not required, under section 8902(j), to provide appellant benefits in excess of the $10,000 limit.

Appellant also cites as support 5 U.S.C. § 8909(b)(2). That section states that OPM shall set aside not more than three percent of the payments to each FEHBA plan as a contingency reserve which may be used, among other purposes, to increase the benefits in the plan from which the reserves are derived. The contingency reserve is a resource OPM can use in negotiations with a carrier to expand plan benefits. The availability of such funds was central to the agreement between OPM and Postmasters to remove the $10,000 limit from the 1983 Plan.

[3] Appellant urges that section 8909(b)(2) grants OPM authority to compel a carrier to provide benefits beyond those in the negotiated plan. The provision apparently has not been construed by the courts. OPM interprets the provision as requiring the carrier's concurrence before contingency reserve funds may be used to extend benefits beyond those within the express terms of the Plan. OPM's interpretation of the provision is entitled to substantial deference, and will be upheld unless unreasonable. *See Filiberti v. Merit Sys. Protection Bd.*, 804 F.2d 1504, 1508 (9th Cir. 1986)

[4] We do not decide the nature or extent of OPM's authority under section 8909(b)(2). Consistent with its view that the carrier's concurrence was necessary, OPM never invoked

authority under the section to direct Postmasters to provide additional benefits. Appellant has not challenged OPM's interpretation of its authority under section 8909(b)(2), nor has he alleged that OPM had a duty to ensure that contingency reserve funds be used to provide him with increased benefits. OPM, in fact, was never named as a defendant in appellant's suit to obtain nursing care benefits.

Contrary to appellant's repeated assertions, the record indicates only that OPM unsuccessfully sought Postmasters' voluntary agreement to amend the 1984 contract. We find no legal or factual bases for appellant's claim that Postmasters or Prudential violated a binding OPM directive.

b) *Catastrophic Protection.*

[5] Appellant next contends that the Catastrophic Protection provision of the Plan ensures him unlimited private duty nursing care benefits. The provision, at page 20 of the Brochure, states:

> CATASTROPHIC PROTECTION
>
> Under the High Option, if, in a calendar year, the out-of-pocket expenses for coinsured eligible expenses exceed $1,000 for a person under Self Only ($2,000 per family under Self and Family) the Plan will pay 100% of the eligible expenses during the remainder of that calendar year.
>
> Expenses incurred for the treatment of mental, psychoneurotic and personality disorders are not included under the Catastrophic Protection Benefit.

[6] This provision requires Postmasters to pay 100% of eligible expenses (when out-of-pocket expenses exceed a certain amount) as opposed to 80% of such expenses it would pay in other situations. The provision does not, however, operate

independent of the $10,000 limitation on private nursing care.

[7] The operative language here is the phrase "eligible expenses." The eligible expenses for nursing care are set out immediately above the Catastrophic Protection provision:

> PRIVATE DUTY NURSING CARE BENEFIT
>
> Benefits for private duty nursing care by a professional registered nurse (R.N.), licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.) are limited to a maximum of $10,000 per person per calendar year.

Appellant's contention that the Catastrophic Protection provision requires Postmasters to provide unlimited private nursing care benefits renders meaningless the phrase "eligible expenses" and ignores the $10,000 limitation stated plainly on the same page of the Brochure and again on page 27. *See Garvey v. Prudential Ins. Co. of America,* 596 F. Supp. 1119, 1126 (E.D. Pa. 1984) (Catastrophic Protection provision is subject to the $10,000 limitation on benefits for private duty nursing care). We find no merit in appellant's alternative argument that the Brochure language is ambiguous and should be construed in his favor. *See Id.* at 1125-26.

4. *State Law Claims.*

The final issue before us concerns the extent to which FEHBA preempts state law. The district court granted summary judgment for appellees in *Hayes v. Prudential* on this issue on the ground that FEHBA's section 8902(m)(1) preempted appellant's state law claims.

This section reads:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or

> benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

5 U.S.C. § 8902(m)(1). The policy underlying section 8902(m)(1) is to ensure uniformity in the administration of FEHBA benefits. *See* H.R. Rep. No. 282, 95th Cong., 1st Sess. 1, 4 (1977).

The parties advance differing views concerning the extent of federal preemption under FEHBA. Appellees contend that the preemption provision is extremely broad, while appellant characterizes the provision as one of "limited preemption" which precludes only those state claims that apply to the "benefit structure" of the plan. The courts are not in agreement on this question. *Compare Blue Cross & Blue Shield of Florida, Inc. v. Department of Banking and Fin.*, 791 F.2d 1501 (11th Cir. 1986)(Florida's Unclaimed Property Act preempted to the extent it conflicts with federal employee benefit plan); *Myers v. United States*, 767 F.2d 1072, 1074 (4th Cir. 1985) (state law which purports to allow recovery of additional benefits not contemplated by a federal insurance contract must be deemed inconsistent with and preempted by FEHBA); and *Tackitt v. Prudential Ins. Co.*, 758 F.2d 1572, 1575 (11th Cir. 1985)("the interpretation of health insurance contracts is controlled by federal, not state, law") *with Howard v. Group Hosp. Serv.*, 739 F.2d 1508, 1510-12 (10th Cir. 1984) (approving state law interpretation of FEHBA Plan provisions).

[8] Appellant contends that his state law claims[1] are not

[1]Appellant alleged the following state law causes of action: (1) breach of contract, (2) breach of the implied covenant of good faith and fair dealing, (3) breach of duties under Cal. Ins. Code § 790.03 (West 1982), (4) civil conspiracy to breach the implied covenant of good faith and fair dealing and to violate Cal. Ins. Code § 790.03 (West 1982), (5) common law fraud, and (6) breach of fiduciary duty.

preempted under section 8902(m)(1), because the claims relate to the manner in which Postmasters and Prudential *processed* his benefits, and not to the "nature or extent of coverage or benefits." No such distinction can be made. Tort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract. *See Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 213-20 (1985) (state tort claim stemming from manner in which a Labor Management Relations Act insurance benefit claim was handled is not independent of insurance contract and therefore is preempted by federal law). Moreover, the claims "relate to" the plan under section 8902(m)(1) as long as they have a connection with or refer to the plan. *Blue Cross*, 791 F.2d at 1504. All appellants' state law claims refer to the plan, and therefore fall under the preemption clause.

[9] Because the state law claims invariably expand appellees' obligations under the terms of the Plan, the claims are inconsistent with the Plan and, hence, preempted under § 8902(m)(1). Our holding is supported by the Supreme Court's recent decision that the Employee Retirement Income Security Act (ERISA) preempts state common law tort and contract claims for benefits under an ERISA-regulated plan. *Pilot Life Ins. Co. v. Dedeaux*, 55 U.S.L.W. 4471 (U.S. Apr. 6, 1987)(No. 85-1043). ERISA's preemption clause is similar to section 8902(m)(1) of the FEHBA.[2] And the Court held that the state claims were preempted despite a saving clause, 29 U.S.C. § 1144(b)(2)(A), which has no counterpart in the FEHBA. Thus, we hold Hayes' state law claims are preempted by the FEHBA. We note that, to the extent the state law claims are predicated on an alleged obligation of appellees to provide benefits in excess of the $10,000 limit stated in the Plan, the claims are moot in light of our ruling that no such obligation existed.

[2]ERISA's preemption clause states that "the provisions of this subchapter . . . shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." 29 U.S.C. § 1144(a).

IV. CONCLUSION

Appellant has brought an effective appeal from the summary judgment in *NLP v. OPM*. Postmasters lawfully reduced private duty nursing care benefits to $10,000 in the 1984 and 1985 Plans, and was not required by OPM or the Catastrophic Protection provision to provide appellant with benefits in excess of that amount. Appellant's state law claims are preempted under 5 U.S.C. § 8902(m)(1). The judgment of the district court is AFFIRMED.

APPENDIX C

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

KIP HAYES,
Plaintiff-Appellant,
vs.
PRUDENTIAL INSURANCE COMPANY OF AMERICA,
NATIONAL LEAGUE OF POSTMASTERS
OF THE UNITED STATES, et al.,
Defendants-Appellees.

CA Nos. 85-5527
85-5528

DC Nos. CV-84-1245-LCN
CV-84-0341-LCN

ORDER

FILED, JUL 21, 1987
Cathy A. Catterson, Clerk
U.S. Court of Appeals

Before: BROWNING, WIGGINS and BRUNETTI, Circuit Judges.

Appellant's petition for rehearing is denied.

APPENDIX D

APPENDIX D

CODE OF FEDERAL REGULATIONS 29 C.F.R.

§ 890.104 Initial decision and reconsideration.

(a) *Who may file.* An employee or annuitant may request OPM to reconsider a decision of an employing office or an initial decision of OPM refusing to permit registration for or change of enrollment or refusing to permit enrollment of an individual as a family member.

(b) *Agency decision.* A request for reconsideration of an agency decision must be filed within 30 calendar days from the date of the written decision stating the right to reconsideration by OPM. The time limit may be extended as provided in paragraph (e) of this section.

(c) *Initial decision.* An OPM decision shall be considered an inital decision as used in § 890.104(a) above when rendered by OPM in writing and stating the right to reconsideration. However, a decision initially rendered at the highest level of review available within OPM will not be subject to reconsideration.

(d) *Reconsideration.* A request for reconsideration must be made in writing, must include the claimant's name, address, date of birth, claim number, if appropriate, name of carrier and reasons for the request.

(e) *Time limit.* A request for reconsideration of an initial OPM decision must be filed within 30 calendar days from the date of OPM's initial decision. OPM may extent the time limit on filing when the individual shows that he/she was not notified of the time limit and was not otherwise aware of it, or that he/she was prevented by circumstances beyond his/her control from making the request within the time limit.

(f) *Final decision.* After reconsideration, OPM shall issue a final decision which shall be in writing, and shall

fully set forth the findings and conclusions of OPM.

§ 890.105 Review of claim for payment or service.

(a) OPM does not adjudicate individual claims for payment or service under health benefits plans. Individual claims for payment or service are adjudicated by the health benefits plan in which the employee or annuitant is enrolled.

(b) If a claim (or portion of a claim) or a service is initially denied by a health benefits plan, the plan will reconsider its denial upon receipt within one year of the denial of written request for reconsideration from the employee or annuitant. Such written request should set forth the reasons why the employee or annuitant believes that the denied claim or service should have been paid or provided. The plan must affirm the denial in writing to the employee or annuitant, setting out in detail the reasons therefor, within 30 days after receipt of the request for reconsideration, or pay or provide the claim or service within such time, unless it requests additional information reasonably necessary to a determination. Such requests by the plan must specifically identify the additional information required and the reason or reasons therefor. If the information requested is not supplied within 60 days of the request therefor, the plan shall make its determination and notify the employee or annuitant as

provided elsewhere in this section.

(c) If a plan either affirms its denial of a claim, or fails to respond to a written request for reconsideration within 30 days of the request, the employee or annuitant may make a written request to OPM's Associate Director for Compensation for a review to determine whether the plan's denial is in accord with the terms of OPM's contract with the carrier of the plan. The plan shall provide written notice to the employee or annuitant of the right to request such a review when it affirms a denial after reconsideration. A request for review will not be honored if received by OPM more than 90 days from the date of the plan's affirmation of the denial. Nor will a request for review be honored if, upon request by the Associate Director, the employee or annuitant does not furnish authorization signed by the patient (or person capable of acting for the patient) for the release of medical evidence to the Associate Director.

(d) In reviewing a claim denied by a plan, the Associate Director will review copies of all original evidence and findings upon which the plan denied the claim and any additional evidence submitted to the Associate Director or otherwise obtained by the plan or Associate Director. Plans will release such evidence and findings to the Associate Director within 30 days of request therefor. Any evidence obtained by the Associate Director in connection with a review of the denied claim will be held privileged and confidential and will be reviewed only by persons having official need to see it.

(e) In reviewing a claim denied by a plan, the Associate Director may request the employee or annuitant to obtain and submit additional medical or hospital records. The Associate Director may also request a confidential advisory opinion from an independent physician, or such other information or evidence as may in the Associate Direc-

tor's judgment be required to evaluate the claim denial. An Associate Director's request for an advisory opinion shall not disclose the identity of the claimant or patient, the plan, or any medical institutions or physicians involved in the claim.

(f) Within 30 days after all evidence requested by the Associate Director has been received, it shall notify the employee and the plan of its findings on review.

§ 890.107 Legal actions.

An action to compel enrollment of an employee or annuitant not excluded by § 890.102(c) should be brought against the employing office. An action to recover on a claim for health benefits should be brought against the carrier of the health benefits plan. An action to review the legality of OPM's regulations or a decision made by OPM should be brought against the Office of Personnel Management, Washington, D.C. 20415.

§ 890.203 Initial decision and reconsideration.

(a)(1) Application for approval of comprehensive medical plans may be made by letter to the Office of Personnel Management, Washington, D.C. 20415. This letter application is to be accompanied by such descriptive material, financial data and documentations as OPM may require in its review process and in the format specified by OPM. Participation of an approved plan becomes effective on the first day of the contract period which is: (i) At least nine months after OPM receives the application, and (ii) at least seven months after OPM receives benefit and rate proposals and all evidence to demonstrate that the plan has met all requirements for approval. At any time, OPM may make a counter-proposal or propose changes on its own motion.

(2) Application for approval of employee organization plans may be made by letter to the Office of Personnel Management, Washington, D.C. 20415, after December 31, 1978, and before January 1, 1980. This letter application is to be accompanied by such descriptive material, financial data and documentations as OPM may require in its review process and in the format specified by OPM. Participation of an approved plan becomes effective on the January 1 which is (i) at least 9 months after OPM receives the application and (ii) at least 6 months after OPM receives all evidence to demonstrate that the plan has met all requirements for approval.

(b) Changes in rates and benefits for approved health benefits plans shall be considered at the discretion of the Director of OPM. If the Director of OPM determines that it is beneficial to enrollees and the Federal Employees Health Benefits Program to invite health plan benefit and/or rate changes for a given contract period, a "call letter" shall be issued to the carrier approximately 9 months prior to the expiration of the current contract period. Any proposal for change shall be in writing, specifically describe the change proposed, and be signed by an authorized official of the carrier. OPM will review any requested proposal for change and will notify the carrier of its decision to accept or reject the change. OPM may make a counter proposal or at any time propose changes on its own motion. Benefits changes and rate proposals, when requested by OPM shall be submitted not less than 7 months before the expiration of the then current contract period, unless the Director of OPM determines that a later date is acceptable. The negotiation period shall begin approximately 7 months before the expiration of the current contract period, and OPM shall seek to complete all benefit and rate negotiations no later than 3 months preceding the contract period to which they will apply.

§ 890.205 Withdrawal of approval of health benefits plans.

(a) The Director may withdraw his or her approval of a health benefit plan or carrier.

(b) Before withdrawing approval, the Director shall cause to be sent, by certified mail, a notice of the carrier stating that he or she intends to withdraw OPM approval of a health benefits plan therefor. The carrier is entitled to reply in writing within 15 days of its receipt of the notice, stating the reasons why approval should not be withdrawn.

(c) On receipt of the reply, or in the absence of a timely reply, the Director shall set a time and place for hearing. The Director shall conduct the hearing or designate a representative to do so, unless the carrier waives hearing. The carrier shall be given notice thereof, by certified mail, at least 15 days in advance of the hearing. The carrier is entitled to appear by representative and present oral and written evidence and argument in opposition to the proposed action.

(d) The Director shall make his or her decision on the record and communicate it to the carrier by certified mail. The Director may set a future effective date for withdrawal of his or her approval.

(e) The Director, in his or her discretion, may reinstate approval on a finding that the reasons for withdrawing approval no longer exist.

APPENDIX E

APPENDIX E

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

METROPOLITAN LIFE INSURANCE COMPANY,
Plaintiff,

vs.

JACQUELINE G. CURTIS,
Defendant.

AND RELATED CROSS-CLAIM.

Case No. CV-83-167-MML

ORDER GRANTING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

Plaintiff brought this action for declaratory judgment. It asserts that it is not obligated to pay to defendant death benefits under the insurance policy issued to Alfred M. Curtis, Sr., defendant's husband. Defendant counterclaimed for money had and received, damages for bad faith, unfair and deceptive business practices and intentional infliction of emotional distress. Plaintiff moved for summary judgment. The motion was argued to the Court on July 11, 1983, and taken under submission. The Court now grants plaintiff's motion for summary judgment.

Plaintiff was the carrier of insurance for Alfred M. Curtis, Sr., under the Federal Employees' Group Life Insurance (FEGLI) Program. The insured designated his children as beneficiaries under the FEGLI policy in accordance with 5 U.S.C. § 8705(a) and 5 C.F.R. § 870.901. Thereafter, Curtis married defendant but did not change the designation of beneficiary under the FEGLI policy. When Curtis died, both the defendant and the children, designated beneficiaries of record, submit-

ted claims for death benefits with plaintiff. Plaintiff paid the benefits to the children of Curtis.

Defendant argues that the premiums on the FEGLI policy were paid out of Curtis's wages, community property under California law. Therefore, the insurance proceeds should be community property and Curtis's designation of his children as beneficiaries is ineffective to deprive defendant of her rights in the community property. Defendant relies on *Carlson v. Carlson,* 113 Cal. Rptr. 722 (1974), which awarded to the spouse half of the FEGLI policy proceeds and points to the Uniformed Services Former Spouses' Protection Act, 10 U.S.C. § 1408, as Congress' response to *McCarty v. McCarty,* 453 U.S. 210 (1981), expressing the legislative intent that state courts should be able to consider military retired pay as marital property according to the state's own domestic relations law. Defendant contends that a similar congressional intent should be found as to the FEGLIA, that state domestic relations law should also apply, because the preemption provisions of 5 U.S.C. § 8709 were to be effective only as to employees who died, were separated or retired after the date of enactment of § 8709. In other words, defendant argues that there was no federal preemption of state domestic relations law in the FEGLIA before October 10, 1980.

Defendant's reading of § 8709 to imply a prior congressional intent that community property law should apply to FEGLI cases is not supported by the language of the FEGLIA and related regulations nor by case law. Section 8705 unequivocally states that death benefits would be paid first to designated beneficiaries and then in the absence of designation to the spouse. Moreover, there were specific regulations for designating and changing beneficiaries, 5 C.F.R. § 870.901, and the insured's right to change the beneficiaries at any time might not be

waived nor restricted. Congressional intent in the FEGLIA has every appearance of being to allow the insured federal employee complete control over the planning of how to provide for his family by designating his beneficiaries. The provisions regarding designation of beneficiaries in the FEGLIA are similar to those in the Servicemen's Group Life Insurance Act, and it is clear that the federal statutory order of precedence of payment preempts state domestic relations law and that strict compliance with the federal requirements in designating beneficiaries was contemplated. *Ridgway v. Ridgway*, 454 U.S. 46 (1981), *Stribling v. U.S.*, 419 F.2d 1350 (8th Cir. 1969).

Defendant's suggestion that the Uniformed Services Former Spouses' Protection Act, 10 U.S.C. § 1408, should affect the instant case is not persuasive. The policies affecting military retirement pay are not necessarily governed by the same considerations as those governing death benefits.

Moreover, it is likely that any concern to let state domestic relations law have effect in cases like *McCarty, supra, Yiatchos v. Yiatchos*, 376 U.S. 306 (1964), and *Carlson, supra*, which involved federal programs and regulations, derives from a factor which is not relevant here. The courts in the last two cited cases were reluctant to allow federal regulations to be exploited in order to work a fraud upon the spouse's rights in community property. As to the congressional response to *McCarty*, 10 U.S.C. § 1408, directing that state domestic relations law should apply, conceivably, a serviceman might be less than enthusiastic about paying alimony and support to a former spouse and might take advantage of anti-attachment provisions in his military pension to avoid such payments. But fraud is not to be presumed if an insured does not designate his spouse but his children as beneficiaries, and

the purpose of the federal group life insurance programs is to allow the insured to choose how he will provide for his family.

The Court need not decide whether *Ridgway, supra*, has implicitly overruled *Carlson, supra*, since *Carlson* is not really apposite here, no fraud by the husband having been alleged. Nevertheless, even if fraud by the husband has been alleged, the defendant should not be able to prevail in a claim against plaintiff in this case. In *Carlson,* the spouse sought to recover from the children (designated beneficiaries) half of the proceeds of the FEGLI policy. In short, the duty of the carrier is clear under the federal statute: to pay the benefits to the beneficiaries designated according to federal regulation. If there were any fraud, the spouse's claim would be against the beneficiaries, not against the carrier.

Since the plaintiff, in paying benefits to the designated beneficiaries, has acted in accordance with its duty under federal law, defendant can have no claim against plaintiff arising from the latter's actions. The Court therefore grants plaintiff's motion for summary judgment and declares that it is not obligated to pay death benefits to the defendant under the FEGLI policy issued to Alfred M. Curtis, Sr.

IT IS SO ORDERED.

IT IS FURTHER ORDERED that the clerk shall serve, by United States mail, copies of this order on counsel for the parties in this matter.

Dated: July 29, 1983

/s/ MALCOM M. LUCAS
Malcom M. Lucas
United States District Judge

APPENDIX F

APPENDIX F

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

GARRY DELANCY AND DELORES DELANCY,
Plaintiffs,

v.

NATIONAL POST OFFICE MAIL HANDLERS, WATCHMEN, MESSENGERS AND GROUP LEADERS, A Division of Liuna; AFL-CIO; MAIL HANDLERS BENEFIT PLAN; and CONTINENTAL ASSURANCE CO. OF CHICAGO, ILL.,
Defendants.

Civil Action No. 84-0695

MEMORANDUM

This case is now before the court on defendants' Motion to Remand and for Partial Judgment on the Pleadings, or, in the alternative, for Summary Judgment.

Plaintiffs Garry and Delores Delancy brought suit to hold defendants National Post Office Mail Handlers Union, Mail Handlers Benefit Plan (MHBP or Plan) and Continental Assurance Co. of Chicago, Illinois (CAC) liable for compensatory and punitive damages on the basis of two separate but inter-related, claims for relief. In the first count, plaintiffs assert a breach of contract by defendants' failure to reimburse plaintiffs for certain medical expenses which Mrs. Delancy incurred while covered as a dependent by the Plan. In the second count, plaintiffs allege that defendants' conduct was intentional and in bad faith, thereby causing plaintiffs' emotional distress and giving rise to a right to recover compensatory and punitive damages.

The case was filed initially in the Court of Common Pleas of Cumberland County, Pennsylvania. It was removed to this court pursuant to 28 U.S.C. §§ 1441 and 1446 on the grounds that (1) the breach of contract claim

arises under federal law, and (2) the separate and independent state law claim falls within the doctrine of pendent jurisdiction (*United Mine Workers v. Gibbs,* 383 U.S. 715 (1966)); 28 U.S.C. § 1441(c). *See* Verified Petition for Removal, ¶ 6.

Defendants thereafter answered the Complaint and asserted a counterclaim which seeks restitution of certain health benefit payments which the Plan contends was made in error to Travacare Laboratories on plaintiff's behalf. Defendants further moved to stay discovery pending adjudication of this potentially dispositive motion. By order dated August 14, 1984, this court granted defendants' motion and stayed all discovery except that which plaintiffs deemed necessary to respond to this motion.

Defendants now move the court for an order remanding plaintiffs' claim that MHBP failed to pay benefits owed them, and defendants' counterclaim for benefits erroneously paid to plaintiffs to the United States Office of Personnel Management for its decision on review pursuant to 5 C.F.R. § 890.105. Alternatively, defendants move, pursuant to Rule 56(b) of the Federal Rules of Civil Procedure, that the court grant summary judgment in their favor.

Defendants further move pursuant to Rules 12(c) and 56(b), Federal Rules of Civil Procedure, for judgment on the pleadings, or, in the alternative, summary judgment on the second count of plaintiffs' Complaint because federal law preempts the claim raised therein.

Factual History

During 1982 and 1983, Garry Delancy, as a federal employee, and his wife Delores, as an eligible dependent, were enrolled in MHBP. In the first count of their Complaint, the Delancys assert that the Plan failed to pay

a valid claim for health benefits incurred in 1982 at the Chambersburg Hospital, Chambersburg, Pennsylvania.

Chambersburg Hospital filed with the Plan a claim assigned by the Delancys for $8,638.25 for services to Mrs. Delancy during a stay from September 29, 1982 to October 20, 1982. The hospital records indicate a diagnosis of "factitious illness." Prior to the adjudication of this claim, however, the Plan processed an earlier-filed claim from Hershey Medical Center in the amount of $3,089.25 for inpatient psychiatric care rendered to Mrs. Delancy upon her transfer there from Chambersburg Hospital on October 20, 1982.

In 1982, the Plan's hospital benefits for mental and nervous conditions were limited to $2,500.00 or the cost of fifty (50) days of hospitalization, whichever was less, during any six month period. Accordingly, the $2,393.50 paid by the Plan on the Hershey Medical Center claim was applied toward the $2,500.00 ceiling on hospital benefits for mental and nervous conditions for the six month period beginning September 29, 1982.

The documentation forwarded to the Plan by the Chambersburg Hospital disclosed that Mrs. Delancy had been hospitalized for the treatment of a "factitious illness." According to the Plan, "factitious illness" is listed by the International Classification of Diseases (ICD) under the heading "Neurotic Disorders, Personality Disorders, and Other Nonpsychotic Disorders." Because the Plan defines "mental and nervous conditions" as those "listed in the [ICD] as psychoses, neuroses, personality disorders, and other non-psychotic mental disorders," the Plan subjected the Chambersburg Hospital claim to the $2,500.00 hospital benefit limitation for mental and nervous conditions. Therefore, because the Chambersburg Hospital claim had been incurred in the same six month period as the Hershey Medical Center claim, and because the Plan

had already paid $2,393.50 to Hershey Medical Center, only $106.50 in hospital benefits was available to be applied toward the Chambersburg Hospital claim. However, rather than make a payment of that amount to the Chambersburg Hospital, the Plan set off this amount against an erroneous $2,023.46 overpayment which it made to Travacare Laboratories on the Delancy's behalf.

Defendants' counterclaim arises out of its alleged overpayment to Travacare Laboratories. During the period September 1983 through February 1983, Travacare Laboratories submitted to the Plan claims for certain equipment and supplies delivered to the Delancy's residence, in the amount of $5,343.88. The Plan said Travacare the entire claim and alleges that it did so in the mistaken belief that it was all for durable medical equipment, an allowable expenditure under the Plan. Now the Plan argues that certain of the claimed expenses were for liquid nutrition which Mrs. Delancy consumed in her home. In 1982 and 1983, the Plan did not cover such supplies when not furnished during a hospital stay. The Plan asserts that it should not have paid Travacare $2,023.46 on the Delancy's account for the liquid nutrition supplies.

Discussion

Defendant MHBP is a health benefits plan sponsored by an employee organization carrier pursuant to the Federal Employees Health Benefits Act (FEHBA or the Act), 5 U.S.C. § 8901/8913. Thus, the MHBP is the product of a federal procurement contract negotiated between the sponsoring employee organization carrier, the Mail Handlers Union, and the United States Office of Personnel Management (OPM). *See* 5 U.S.C. § 8902.

FEHBA is a comprehensive statutory scheme regulating all aspects of federal employee health benefits plans,

including eligibility for coverage, 5 U.S.C. §§ 8902(f), 8905, 8908, standards for termination of coverage, §§ 8902(g) and (h), and benefit types, levels and rates, §§ 8902(d) and (i), 8904. In addition, FEHBA mandates that OPM has the authority to require carriers to pay benefits in any individual case if OPM finds the enrollee entitled to such under the contract with the carrier, § 8902(j), places general supervisory authority of the employee health benefits program established by statute in the hands of OPM and empowers OPM to issue regulations necessary to carry out the purpose of the Act, § 8913.

The Request for Remand

The Plan's contract with OPM, in accordance with statutory requirements found at 5 U.S.C. § 8902(j) and 8913, establishes a disputed claims review and resolution procedure which provides for OPM review of a FEHBA plan's decision to deny an individual claim for benefits. *See* 5 C.F.R. § 890.105. If, upon conducting such a review, OPM "finds that the [enrollee] is entitled [to the claimed benefit] under the terms of the contract" the Plan must pay the claim, notwithstanding its objection. 5 U.S.C. § 8902(j). Defendant argues that OPM has not had the occasion to review the benefit claim disputes which are now before the court for adjudication and that, as a matter of sound judicial policy, this court should remand the claims to OPM for administrative review.

Plaintiffs argue that their claim was not denied until after this lawsuit was commenced. In fact, plaintiffs aver that they have never been notified of the denial of their claim, although they have been informed by the hospital that the claim was denied. Absent a denial from the Plan, plaintiffs were without an administrative remedy and the exhaustion requirement should be waived.

Except where mandated by statute, the "exhaustion of administrative remedies is not an inexorable command, but is a matter of sound judicial discretion." *Cerro Metal Products v. Marshall,* 620 F.2d 964, 970 (3rd Cir. 1981). In exercising that discretion, the court must look to a number of factors, *see Susquehanna Valley Alliance v. Three Mile Island Nuclear Reactor,* 619 F.2d 231, 246 (3rd Cir. 1980), and is generally guided by the rationales advanced for this judicially created doctrine. Those purposes include: (1) the promotion of administrative efficiency by avoiding premature interference with agency processes; (2) respect for executive autonomy by allowing an agency to correct its own errors; (3) facilitating judicial review by giving the court the benefit of the agency's expertise; and (4) serving judicial economy by having the administrative tribunal compile the factual record. *Cerro Metal Products,* 620 F.2d at 970. The requirement also shows deference to another branch of government; when Congress has provided an administrative remedy which is capable of resolving a controversy, such a remedy should be utilized. *Id.* at 71; *American Fed. of Gov. Emp. Local 1994 v. Resor,* 442 F.2d 993, 994 (3rd Cir. 1971).

The Third Circuit has recognized only three exceptions to the exhaustion doctrine: (1) when the nonjudicial remedy is clearly shown to be inadequate to prevent irreparable injury; (2) when resort to the nonjudicial remedy would clearly violate statutory or constitutional rights; and (3) when exhaustion would be futile. *Republic Industries v. Central Pa. Teamsters,* 693 F.2d 290, 293 (3rd Cir. 1982). The court has also stated that "these exceptions apply only in 'extraordinary circumstances,' when the remedy to be exhausted, though supported by the underlying policy justifications of the doctrine, should not be compelled because of some countervailing justifica-

tions of the doctrine, should not be compelled because of some countervailing consideration." 693 F.2d at 294.

The court does not find any of the recognized exceptions applicable to the instant case and, indeed, finds that a remand would serve important interests. Congress, in enacting the statute, clearly intended that a governmental agency should be the initial forum for dispute resolution. The agency's procurement of this contract demonstrates a peculiar expertise in interpreting the contract provisions. Finally, the agency can assist the court in compiling a factual record should further judicial intervention be necessary.

Because no formal notice had been given at the time suit was commenced, plaintiffs could not exhaust administrative remedies and therefore, should not be penalized by dismissal of the suit. The court will remand plaintiffs' claim as well as defendants' counterclaim for administrative review, but will retain jurisdiction so that the parties may return to this court if the administrative remedy to resolve the dispute.

The Preemption Claim

In the second count of the Complaint, plaintiffs allege that MHBP's refusal to pay the Chambersburg Hospital claim in issue here is "without explanation" and "without basis." Plaintiffs assert that the refusal was "an intentional act of bad faith" and "negligent." (Complaint, ¶¶ 12-15). As a result of these actions, plaintiffs are alleged to have suffered severe emotional distress, fear, humiliation, embarrassment and mental anguish and demand compensatory and punitive damages.

It appears that plaintiffs allege a cause of action for insurer bad faith, a tort which has been recognized in some, but by no means all, jurisdictions. *Compare,* e.g., *Gruenberg v. Aetna Ins. Co.,* 9 Cal. 3d 566, 574, 510 P. 2d

1032, 1037, 108 Cal. Rptr. 480, 485 (1973), and *D'Ambrosio v. Pennsylvania National Mutual Casualty Ins. Co.,* 494 Pa. 501, 431 A.2d 966, 970 (1981). The MHBP is *not* an insurance contract governed by state law. As a creature of FEHBA, 5 U.S.C. § 8901 *et seq.,* the MHBP is a government procurement negotiated between the sponsoring employee organization carrier and OPM pursuant to 5 U.S.C. § 8902, to enable the Federal Government to offer to its employees health benefits as a term and condition of employment. As a federal procurement contract, it is governed by federal, not state, law. *Tackitt v. Prudential Insurance Co., et al.,* 758 F.2d 1572 (11th Cir. 1985).

Plaintiffs seek to impose common law tort liability on the government contractor. However, this court finds that the FEHBA, because of its comprehensive nature and special subject matter preempts application of state laws to the MHBP.

It is well established that within constitutional limits Congress may preempt state law by enacting a

> scheme of federal regulation so pervasive as to make reasonable the inference that Congress left no room to supplement it, because the Act of Congress may touch a field in which the federal interest is so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject
>
> . . . .
>
> *Pacific Gas & Electric v. State Energy Resources Conservation Devel. Comm'n,* ____ U.S. ____, 103 S.Ct. 1717, 1744 (1983); *see also Chicago N.W. Transportation Co. v. Kalo Brick & Tile Co.,* 450 U.S. 311, 317 (1981).

The nature of the subject matter regulated by the FEHBA — the provision of health benefits insurance for federal employees as a benefit of their employment — is one uniquely of federal concern.

In a recent decision which offers some assistance here, the Supreme Court has held that federal labor law preempts the same state law based insurer bad faith tort claim which plaintiffs here allege. *Allis Chalmers Corp. v. Lueck,* ____ U.S. ____, 53 U.S.L.W. 4463 (April 16, 1985). The specific issue in *Lueck* was whether section 301 of the Labor Management Relations Act, 29 U.S.C. § 185(a), preempted the Wisconsin state law tort action for bad faith delay in making disability payments due under a collectively bargained plan. 53 U.S.L.W. at 4464. In resolving that issue in favor of preemption, the Court noted that section 301 reflects a congressional policy that federal uniformity was to prevail over inconsistent local rules, 53 U.S.L.W. at 4465. Therefore,

> questions relating to . . . what legal consequences were intended to flow from breaches of that [federal law governed] agreement, must be resolved by reference to uniform federal law, whether such questions arise in the context of a suit for breach of contract or in a suit alleging liability in tort.

53 U.S.L.W. at 4465.

In order to accommodate these policies, the court found that the analysis must focus on whether the tort at issue confers state law rights independent of any right established by the federal law contract, or whether evaluation of the tort claim is inextricably intertwined with consideration of the terms of that contract. Thus, the Court held that "*[i]f the state tort law purports to define the meaning of the contract relationship, that law is preempted.*" 53 U.S.L.W. at 4466 (emphasis supplied).

Lueck seems particularly instructive in this case. Here the federal interest underlying FEHBA is dominant, thereby precluding state regulation, from two viewpoints: first, the cost of the program to the government and employees; and second, the necessity of uniform administration and decision-making in plans such as MHBP, which have enrollees in many states. If state laws and remedies were permitted to impose special requirements on FEHBA plans, the cost of business would increase over that of a uniformly regulated federal program. The need for uniform administration is particularly important when enrollees have multi-state contacts. *See, LaBelle v. Blue Cross & Blue Shield United of Wisconsin*, 548 F.Supp. 251, 253 (W.D. Wisc. 1982). Finally, the scheme of federal regulation here is so pervasive as to clearly indicate that Congress has precluded state regulation.[1]

To be sure, the holding in *Lueck* is not binding here and, indeed, is a narrow one. "We pass no judgment on whether this suit also would have been pre-empted by other federal laws governing employment or benefit plans." U.S.L.W. at 4468. However, the analysis is persuasive.

In addition, OPM interprets 5 U.S.C. § 8902(m)(1), the section which forms the basis for the Delancys' claim, to preempt state insurer bad faith tort claims. (Declaration of Kevin J. Burns, OPM Assistant Director for Insurance Programs, Exh. A to Barnett Declaration filed Feb. 8, 1985.) It is settled that the interpretation of a statute by an agency which is charged with administering that statute, shall be shown "great deference" by the courts,

---

[1]The scope of FEHBA's coverage includes conditions of eligibility for coverage, benefits, contributions and required reserves; qualifications of carriers, disclosure to employees, vesting of supervisory authority in a federal agency and original jurisdiction in the federal courts. 5 U.S.C. §§ 8902, 8903, 8904, 8906, 8909, 8912, 8913.

provided that the interpretation is a reasonable one. *Udall v. Tallman,* 380 U.S. 1, 6 (1965).

For the reasons already discussed, the court finds the agency's interpretation to be reasonable and is supported by the legislative history, as cited in the Burns declaration.

Accordingly, the court will grant judgment in favor of the defendants on the second count of the Complaint.

/s/ SYLVIA H. RAMBO

Sylvia H. Rambo
United States District Judge

Dated: June 25, 1985

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF
PENNSYLVANIA

GARRY DELANCY and DELORES DELANCY,
Plaintiffs,
v.
NATIONAL POST OFFICE MAIL HANDLERS,
WATCHMEN, MESSENGERS AND GROUP LEADERS,
A Division of Liuana; AFL-CIO;
MAIL HANDLERS BENEFIT PLAN; and
CONTINENTAL ASSURANCE CO. OF CHICAGO, ILL.,
Defendants.

Civil Action No. 84-0695

ORDER

In accordance with the accompanying memorandum, IT IS HEREBY ORDERED THAT:

1. The first count of the plaintiffs' Complaint and the defendants' counterclaim are remanded to the United States Office of Personnel Management for its review pursuant to 5 C.F.R. 890.105.

2. The defendants are to inform the court of the agency's disposition of these claims within ten (10) days of that decision, but in any event, shall report back to the court within ninety (90) days of the date of this order.

3. Judgment is granted in favor of the defendants and against the plaintiffs on the second count of the Complaint. The Clerk of the Court is directed to enter the judgment.

/s/ SYLVIA H. RAMBO
Sylvia H. Rambo
United States District Judge

Dated: June 25, 1985

APPENDIX G

APPENDIX G
List of Companies supplied pursuant to Rule 28.1

Prudential has no parent corporation. Prudential has no subsidiaries or affiliates which have outstanding any equity securities which are publicly traded. Set forth below is a list of corporations in which Prudential has, or has the right to acquire, more than 10% of a class of equity security which is publicly traded. These investments were acquired in the normal course of Prudential's investment operations and not for the purpose of acquiring control of these corporations.

Air Express International Corp.
BRNF Liquidating Trust
Communications Transmission, Inc.
C.P. National Corporation
DMI Furniture
Foodmaker, Inc.
Global Natural Resources
Grubb & Ellis
Intermet Corporation
Manufactured Homes
Maxus Energy
Miller Shoe Industries
Public Service Company of New Hampshire
Scan-Optics
Specialty Equipment Companies, Inc.
Tom Brown
Vista Chemical Co.
Wellman
Western Union Telegraph Co.
Prudential Special Equity Fund
United States High Yield Fund

PROOF OF SERVICE BY MAIL

I am a citizen of the United States and a resident of the City and County of Los Angeles; I am over the age of eighteen years and not a party to the within action; my business address is: 1706 Maple Avenue, Los Angeles, California.

On January 22, 1988, I served the within Brief in Opposition in re: "Kip Hayes vs. Prudential Insurance Co." in the United States Supreme Court, October Term 1987, No. 87-818;

On the Parties in said action, by placing Three copies thereof enclosed in a sealed envelope with postage fully prepaid, in the United States post office mail box at Los Angeles, California, addressed as follows:

Robert S. Greenspan, Esq.
Edward R. Cohen, Esq.
Appellate Staff, Civil Division
Room 3127
Department of Justice
Washington, D.C. 20530

Marcia Hughes, Esq.
Casey, Gerry, Casey, Westbrook,
Reed & Hughes
110 Laurel Street
San Diego, CA 92101

Harvey R. Levine, Esq.
Shernoff & Levine
1200 Third Avenue, Suite 1400
San Diego, CA 92101-4157

John T. Kotelly, Esq.
Dickstein, Shapiro & Morin
2101 L Street, N.W.
Washington, D.C. 20037

Raymond J. Coughlan, Jr., Esq.
Lillick, McHose & Charles
110 West A Street, Suite 1260
San Diego, CA 92101

All Parties required to be served have been served.

I certify (or declare), under penalty of perjury, that the foregoing is true and correct.

Executed on January 22, 1988, at Los Angeles, California

Ce Ce Medina

CE CE MEDINA